W.C. 101

F.R.O.I. process

MT State Fund Claims process and parties involved

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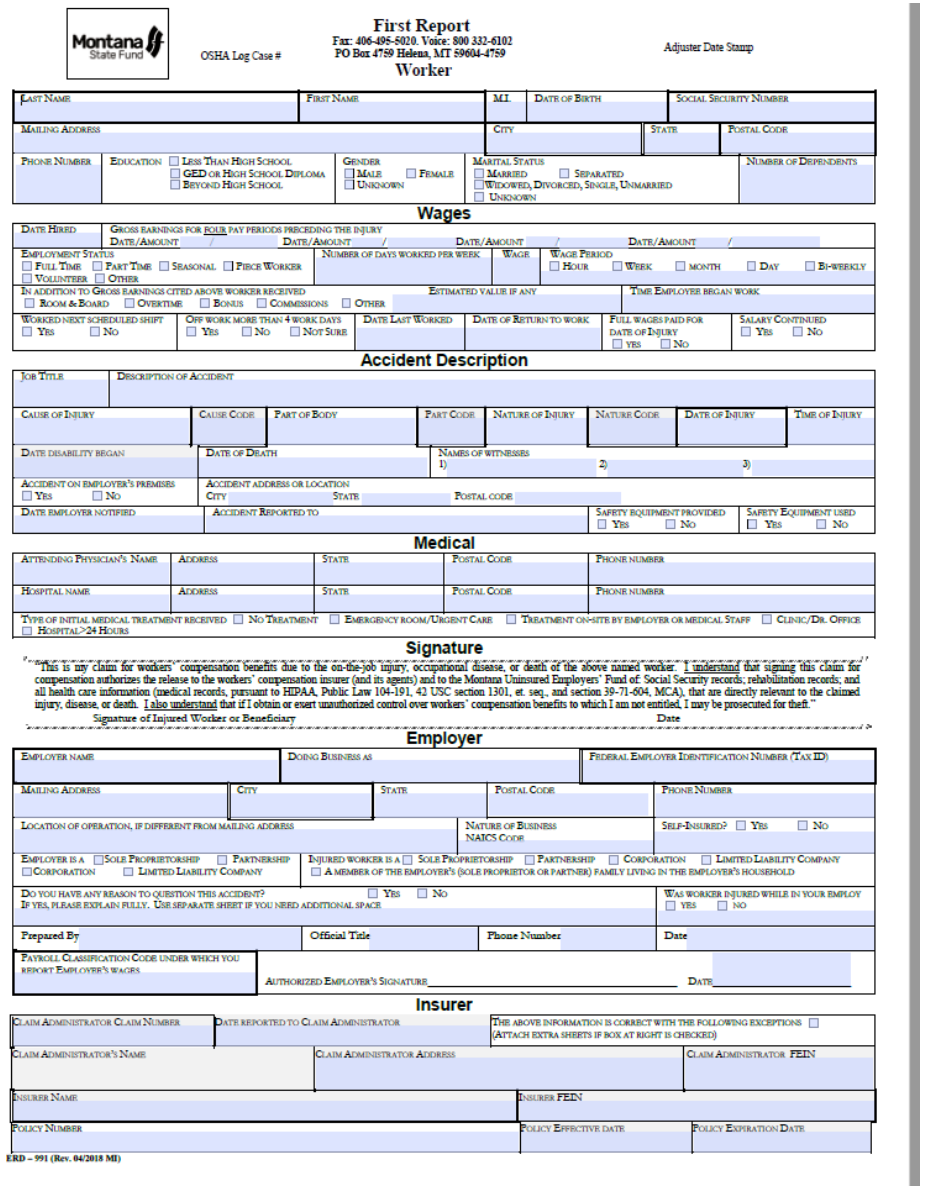
F.R.O.I. (First Report of Injury)

- What are the expectations and why important?
    - Getting claim submitted asap allows MT State Fund to start gathering details and investigating claim
        - Legal standard is within six days of receiving claim, but the sooner the better

*There are also video resources and links available for review on the MT State Fund and the WCMB websites:
MSF - Report an Injury (montanastatefund.com)
Injured at Work (mt.gov)

F.R.O.I. (First Report of Injury)

To complete a FROI, you will need several pieces of required information.
First, you must have information about the **Employer**
Montana State Fund Policy Number
Next, you will need to provide information about the **Injured Employee:**
Name
Social Security Number
Birth Date
Gender
Mailing Address
Contact Phone *
Hire Date *
Employee Classification Code
Job Title
Employment Status *
Worker Type
Non-employee Detail Type
** Required only if you are using a login*
Finally, you will need to provide information about the **Accident or Injury:**
Date of the accident or injury
Description of the accident or injury
Injured part of body
Location where accident or injury occurred
Date employer notified and to whom it was reported
Type of facility where the injured employee received treatment, if any
Whether the injured employee worked the next scheduled shift and if not, the last date worked
Whether the injured employee was off work more than 4 days
Does the Employer question the claim?
After submitting the claim with the minimal requirements, an MSF customer service specialist will contact you if additional information is needed. You also have the option to fill out the form in its entirety.



Montana State Fund

OSHA Log Case #

First Report
Fax: 406-495-5020. Voice: 800 332-6102
PO Box 4759 Helena, MT 59604-4759

Adjuster Date Stamp

Worker

Last Name | First Name | M.I. | Date of Birth | Social Security Number

Mailing Address | City | State | Postal Code

Phone Number | Education ☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School | Gender ☐ Male ☐ Female ☐ Unknown | Marital Status ☐ Married ☐ Separated ☐ Widowed, Divorced, Single, Unmarried ☐ Unknown | Number of Dependents

Wages

Date Hired | Gross Earnings for four pay periods preceding the injury: Date/Amount / Date/Amount / Date/Amount /

Employment Status ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Piece Worker ☐ Volunteer ☐ Other | Number of Days Worked Per Week | Wage | Wage Period ☐ Hour ☐ Week ☐ Month ☐ Day ☐ Bi-Weekly

In addition to Gross Earnings cited above worker received ☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other | Estimated Value if any | Time Employer Began Work

Worked Next Scheduled Shift ☐ Yes ☐ No | Off Work More Than 4 Work Days ☐ Yes ☐ No ☐ Not Sure | Date Last Worked | Date of Return to Work | Full Wages Paid for Date of Injury ☐ Yes ☐ No | Salary Continued ☐ Yes ☐ No

Accident Description

Job Title | Description of Accident

Cause of Injury | Cause Code | Part of Body | Part Code | Nature of Injury | Nature Code | Date of Injury | Time of Injury

Date Disability Began | Date of Death | Names of Witnesses 1) 2) 3)

Accident on Employer's Premises ☐ Yes ☐ No | Accident Address or Location City State Postal Code

Date Employer Notified | Accident Reported To | Safety Equipment Provided ☐ Yes ☐ No | Safety Equipment Used ☐ Yes ☐ No

Medical

Attending Physician's Name | Address | State | Postal Code | Phone Number

Hospital Name | Address | State | Postal Code | Phone Number

Type of Initial Medical Treatment Received ☐ No Treatment ☐ Emergency Room/Urgent Care ☐ Treatment On-Site by Employer or Medical Staff ☐ Clinic/Dr. Office ☐ Hospital>24 Hours

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary | Date

Employer

Employer Name | Doing Business As | Federal Employer Identification Number (Tax ID)

Mailing Address | City | State | Postal Code | Phone Number

Location of Operation, if different from mailing address | Nature of Business NAICS Code | Self-Insured? ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company | Injured Worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space | Was worker injured while in your employ ☐ Yes ☐ No

Prepared By | Official Title | Phone Number | Date

Payroll Classification Code under which you report employee's wages | Authorized Employer's Signature _____ Date _____

Insurer

Claim Administrator Claim Number | Date Reported to Claim Administrator | The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Claim Administrator's Name | Claim Administrator Address | Claim Administrator FEIN

Insurer Name | Insurer FEIN

Policy Number | Policy Effective Date | Policy Expiration Date

ERD – 991 (Rev. 04/2018 MI)

The available details will fill into this template document

The information available at F.R.O.I. filing will determine next contacts and steps for the claim.

Post F.R.O.I. filing

- Who might contact you and why?
  Customer Service Specialist (CSS)-first point of contact with MSF. May contact you if additional details are needed to establish the claim. Can also assist with online FROI.
  Claims Examiner- the agencies have an assigned examiner or examiner team to handle their claims. Some companies in the industry also call examiners "claims adjusters". The MT State Fund examiner is responsible for the investigation of the claim, determining compensability, and paying the correct benefits. The examiner is likely to contact you when the claim is formally assigned to them and they need more information on the claim. The examiner must follow MT worker's compensation laws and regulations when considering claims. There is certain information that the examiner is prohibited from sharing with other parties.
  Claims Assistant- there are limited situations in which you may hear from a claims assistant (C.A.) They could contact you to request employee wage information details or basic info on the claim.
  Other important members of your MSF service team:
  Safety Management Consultant
  Underwriter
  Claims Management

  It is important to note that many claims will not involve or require additional contact from MT State Fund. Claims that are formally assigned to an examiner will need claim determination and likely lead to them contacting you.

Post F.R.O.I. filing

If the claim is assigned to an examiner, the investigation will likely include:

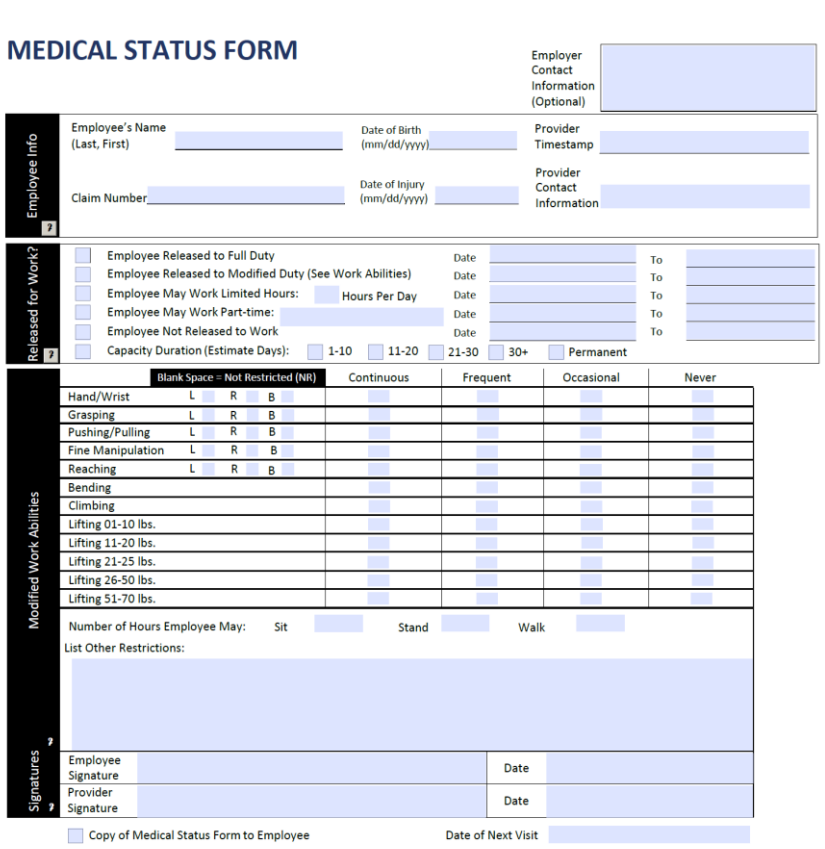
- The examiner may contact you to get additional information **(if you note the claim as being questioned, we require that the examiner contact you for more information)**
- The examiner may complete a recorded interview with the employee to memorialize the facts of the claim
- **The examiner will request pertinent medical documentation**
- On some claims, the examiner may need to enlist the assistance of an outside resource such as a Certified Rehab Counselor.
- The examiner will be working closely with other in-house resources at MT State Fund (i.e. nurse case managers, claims attorneys, claims managers, claims support team, etc.)
- The examiner may also need to write letters to the employee's treating physician (the employee will be copied on these inquiries)
- A small percentage of claims could be questionable and require even more examination. When you have credible, factual information you can consider the following:

Post F.R.O.I. filing

Report suspicious activity by calling our Fraud Hotline: **888-MTCRIME.** All contacts will remain strictly confidential. Employers or designated managers or supervisors should call **800-332-6102.**

One of the most important resources we have to combat fraud are tips we receive from citizens who believe that a fraudulent act has been committed. Use this partial list of indicators:

- The alleged injury occurred early on a Monday morning, or late on a Friday afternoon but was not reported until the following Monday.
- The accident was not witnessed by fellow employees.
- The claimant delays reporting the accident.
- The time of accident was outside normal working hours or on a Saturday or Sunday.
- The injury occurred in a manner or location outside of the employee's work assignment.
- The alleged injury occurred shortly after the employee was hired.



MEDICAL STATUS FORM

Employer Contact Information (Optional)

Employee Info

Employee's Name (Last, First)

Date of Birth (mm/dd/yyyy)

Provider Timestamp

Claim Number

Date of Injury (mm/dd/yyyy)

Provider Contact Information

Released for Work?

- Employee Released to Full Duty — Date — To
- Employee Released to Modified Duty (See Work Abilities) — Date — To
- Employee May Work Limited Hours: Hours Per Day — Date — To
- Employee May Work Part-time: — Date — To
- Employee Not Released to Work — Date — To
- Capacity Duration (Estimate Days): 1-10 11-20 21-30 30+ Permanent

Modified Work Abilities

Blank Space = Not Restricted (NR)		Continuous	Frequent	Occasional	Never
Hand/Wrist	L R B				
Grasping	L R B				
Pushing/Pulling	L R B				
Fine Manipulation	L R B				
Reaching	L R B				
Bending					
Climbing					
Lifting 01-10 lbs.					
Lifting 11-20 lbs.					
Lifting 21-25 lbs.					
Lifting 26-50 lbs.					
Lifting 51-70 lbs.					

Number of Hours Employee May: Sit Stand Walk

List Other Restrictions:

Signatures

Employee Signature		Date	
Provider Signature		Date	

Copy of Medical Status Form to Employee

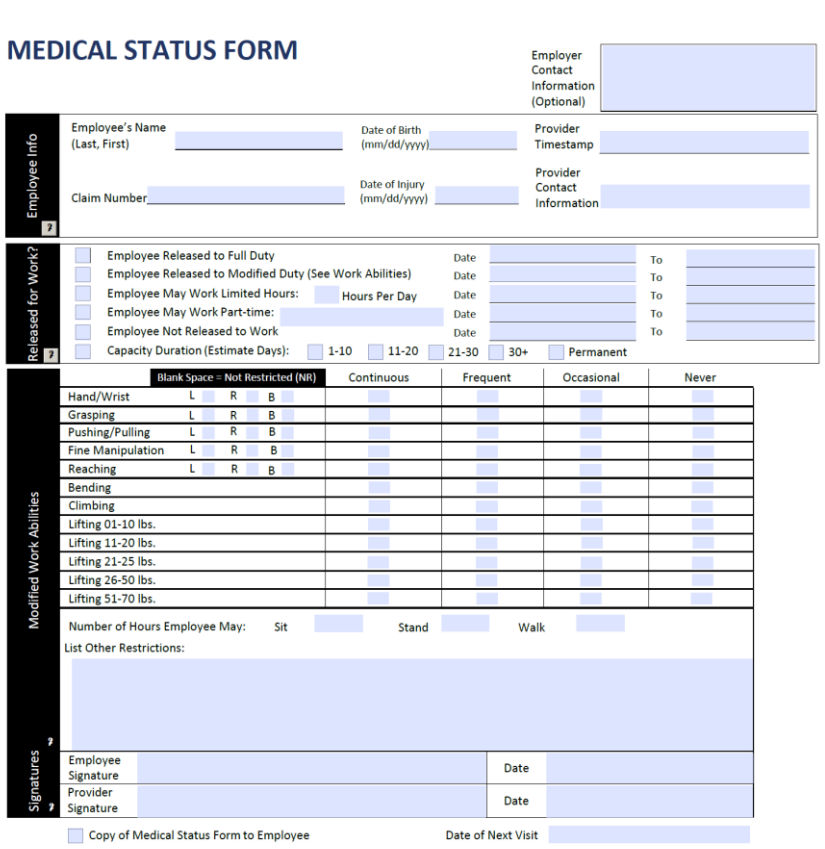
Date of Next Visit

Documents you are likely to see for a claim

The medical status form is designed by Labor and Industry.

Due to the private, sensitive nature of certain employee information there are three "versions" of the document.

This document is the "employer version".



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Provider Signature		Date	

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Claim communications and details that can be shared

Typically the employer version of the medical status form is a great starting point.

Communication should be frequent between the examiner and agency to determine if the agency can bring an employee back to work with work restrictions.

The medical status form should provide details to guide that conversation.

MT State Fund claims staff <u>cannot</u> share:

Employee diagnosis or medical treatment plan

If a medical provider is not providing complete medical status, MT State Fund has a medical team that can step in to assist and look for solutions.

Montana State Fund

Questions?
Discussion time

Montana
State Fund